MISSOURI DEPARTMENT OF HEALTH
BUREAU OF FAMILY HEALTH

MEDICAL REPORT

FORM 2

TO: Prosecuting Attorney	COUNTY

EXAMINATION INFORMATION

DATE OF EXAMINATION	TIME	LOCATION OF EXAMINATION	THOSE PRESENT DURING THE EXAMINATION

PATIENT INFORMATION

PATIENT NAME	SEX
	☐ M ☐ F

PATIENT STATEMENT ABOUT SEXUAL ASSAULT INCIDENT

DATE OF INCIDENT	TIME	LOCATION AND COUNTY

PATIENT DATE OF BIRTH	BLOOD PRESSURE	HEIGHT	WEIGHT	PULSE	TEMPERATURE	LAST MENSES

CURRENT MEDICATION

INJURIES

FACE	NECK
BREASTS	**PUBIC AREA**
EXTREMITIES	**OTHER**

GENITAL EXAMINATION	
VULVA	SCROTUM
VAGINA	TESTES
HYMEN	EPIDIDYMIS
CERVIX	PENIS
UTERUS	PROSTATE
ANUS	ANUS

LABORATORY TESTS OF FOLLOWING PHYSICAL SPECIMENS ORDERED:

DATE OF REPORT	SIGNATURE OF MEDICAL STAFF MEMBER	TYPE OR PRINT NAME,TITLE AND TELEPHONE NUMBER
	►	